

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06922		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06920	
1. DECEASED-NAME (Type or print) Polly A Austin				2a. DATE OF DEATH May Month 5 Day 69 Year		2b. HOUR 2300p	
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH 24 November 1933		6. AGE (In years lost 1 day) 35 YRS.	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? United States		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH APG Aber. Prov. Grd.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN APG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Thomas J Braswell		15. MOTHER'S MAIDEN NAME Addie L Cooper		13e. STREET AND NUMBER 2811D Middleboro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 262-44-9486		17. INFORMANT Oscar Austin Address 2811 D Middleboro, APG, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 5 May 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward Zobian		22c. DATE SIGNED 6 May 69		22d. PHYSICIAN'S NAME (Type) EDWARD ZOBIAN, MAJ, MC 22e. ADDRESS US Kirk Army Hospital, APG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7 May 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Cemetery Orlando, Florida		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Walter McCumber		ADDRESS Farring Funeral Home		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

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08/e-11-53

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Jameson's Critique

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06923		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08413	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <i>Isaiah Barnhill</i>			2a. DATE OF DEATH Month Day Year <i>May 13, 1969</i>			2b. HOUR <i>2:30 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>March 18, 1888</i>		6. AGE (in years last birthday) <i>81</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>mess attendant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>V.A. Hospital</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Havre de Grace</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>No Record</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>No Record</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. James Lane, Havre de Grace, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Portal Cirrhosis</i> <i>5718</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Thrombosis, Left Branch of Portal Vein</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (a) <i>Bronchopneumonia, Confluent, Left Lower Lobe</i> (b) <i>Uremia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> , 19 <i>69</i> , to <i>5/13</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/13</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George T. Stansbury</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/15/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		22e. ADDRESS <i>569 Revolution Street Havre de Grace, Maryland 21078</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Wilmington Md</i>	
24. FUNERAL DIRECTOR <i>Elmer E. Bullock</i>		ADDRESS <i>Havre de Grace</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JUN 16 1969</i>							

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06924

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06921

1. DECEASED-NAME (Type or Print) Harold E Beaber			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year May 10 1969			2b. HOUR M			
3. SEX M	4. RACE W	5. DATE OF BIRTH Oct 1, 1928	6. AGE (In years last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month May Day 10 Year 1969			2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Calif.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Harford			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Doa Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier U.S. Army			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington			13b. CITY OR TOWN Pierce		13c. INSIDE CITY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13d. STREET AND NUMBER 51215 Prospect			
14. FATHER'S NAME First Oscar E. Middle Beaber Last Keen			15. MOTHER'S MAIDEN NAME First Irene J. Middle Keen Last Keen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO. 1-20-195-10-49			17. INFORMANT Army Records			ADDRESS Aberdeen Proving Gnd, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fracture Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year May 10 1969 HOUR A.M. 8:30 PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) IEX Highway 24		21f. LOCATION Street or R.F.D. No. Aberdeen		City or Town Hd. Md.		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C. Palmer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 5-11-69			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) Bel Air, Md. 21014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-16-69		23c. NAME OF CEMETERY OR CREMATORY Fern Hill Cemetery		23d. LOCATION (City or Town) Aberdeen		(County) Gray's Harbor	(State) Wash.
24. FUNERAL DIRECTOR Paul R. Crouch			ADDRESS Grant Funeral Home			25a. REC'D BY REGISTRAR MAY 15 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item 6 Film G413 6/4/69 kk													
CERTIFICATE OF DEATH													
06922													
1. DECEASED NAME (Type or print) Nelson Brandt Bell						2a. DATE OF DEATH Month 5 Day 29 Year 1969			2b. HOUR 9:05 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9 March 1908			6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OR WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford							
10. CITY OR TOWN OF DEATH Har-de-Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Salesman (ret.)			12b. KIND OF BUSINESS OR INDUSTRY Nat. Bis. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 481, Rolling Dale			
14. FATHER'S NAME First Harry Middle Bell Last Bell				15. MOTHER'S MAIDEN NAME First Catherine Middle Brandt Last Brandt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 212-07-4183		17. INFORMANT Beatrice Bell, R.D. 1, Churchville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Cardiac Decompensation 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Massive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 5-26 , 19 69 , to 5-29 , 19 69 , that (I) (we) last saw the deceased alive on 5/29 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dante Monackil M.D.						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-29-69			
22d. PHYSICIAN'S NAME (Type) DAVID MONACKIL, M.D.						22e. ADDRESS 281 N. Union Ave. Har-de-Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1 June 1969		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery,				23d. LOCATION (City or Town) (County) (State) Perryman, Md. Harford Md.					
24. FUNERAL DIRECTOR Walter McCauley Sr.						ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Richard Judge			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06926

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06923

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
STEPHEN		EDWARD	Callahan		MAY 19 1969		4:30 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male	White		May 18, 1969		YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Md	USA				Hartford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace		Hartford Mem. Hosp.		none		none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md		Hartford		Aberdeen				630 Stepney Rd.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Robert		William	Callahan		Betty		Jane	Tibbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		Md.
no		none		Robert W. Callahan,		630 Stepney Road,		Aberdeen
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>								5 1/2 hrs
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>776.2</u>								5 1/2 hrs
(b) <u>Prematurity</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town
								County
								State
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 18, 1969</u> , to <u>MAY 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAY 19, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>Barry J. Plunkett, Jr.</u>								<u>5-19-69</u>
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Barry J. Plunkett, Jr.,				617 W. Bel Air Avenue, Aberdeen, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)
Burial		May 20, 1969		St. Francis Cemetery		Abingdon		Hartford Md.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Howard K. McComas & Son, Abingdon, Md.						MAY 21 1969		<u>Chas. J. Jones</u>

08882

DEPARTMENT OF DEATH

DIVISION OF VITALS

08882

DECEASED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1621

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
John Stanley Chilcoat						May 24, 1969		12:20 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		July 17, 1890		78		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		U.S.A.				Harford County, Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace		Harford Memorial Hospital		Operating Engineer		Civil Service					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Harford		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		341 East Broadway			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME	
John Pearce Chilcoat				Laura Alloway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Name and address)		17. INFORMANT (Name and address)					
No		217-01-6461		Mrs. Marie E. Chilcoat		341 East Broadway, Bel Air, Maryland 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastasis, terminal stage											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary cap of the lung											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work											
22a. I certify that (I) (this hospital) attended the deceased from 5-16, 1969, to 5-24, 1969, that (I) (we) lost the deceased on 5-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Henry H. Kwak, M.D.								May 24, 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. REGISTRAR'S SIGNATURE					
				610 S. Union Ave., Havre de Grace, Md.		Charles Judge					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		May 26, 1969		Bel Air Memorial Gardens		Bel Air, Harf. Co., Md. 21014					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph William Foster				W. Broadway & Williams, Bel Air, Maryland 21014		MAY 27 1969					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15, 11-69
45M - 11-69

06928		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06925					
1. DECEASED NAME (Type or print) <u>Phillip Levi Colston</u>						2a. DATE OF DEATH		2b. HOUR			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 21, 1917</u>		6. AGE (In years last birthday) <u>51</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> Md.					
10. CITY OR TOWN OF DEATH <u>Harre-de-Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>SUPERVISOR M.T.D. SEC.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>A.P.G.</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Bel Air</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Box 19, R.D. #2</u>			
14. FATHER'S NAME First <u>Robert A</u> Middle <u>Colston</u> Last <u>Levi</u>		15. MOTHER'S MAIDEN NAME First <u>Mammie</u> Middle <u>Levi</u> Last <u>Levi</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WORLD WAR II</u>		16b. SOCIAL SECURITY NO. <u>225-12-2895</u>		17. INFORMANT <u>Mr. Elizabeth T. Colston</u>		Address <u>Max Phil Rd. Bel Air, Md. RD #2 Box 19</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>2070</u> DUE TO, OR AS A CONSEQUENCE OF <u>Thrombocytopenia, marked?</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2-3 months</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21, 1969</u> , to <u>5-2, 1969</u> , that (I) (we) last saw the deceased alive on <u>5-2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edward C. Loo</u>		22c. DATE SIGNED <u>5/3/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22e. ADDRESS <u>Harre de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAY 5 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CH. YD.</u>		23d. LOCATION (City or Town) (County) (State) <u>CHORCHVILLE HARFORD, MD.</u>					
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		24b. ADDRESS <u>Harre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>					

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CENTRAL BANK OF INDIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06929

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06926

1. DECEASED-NAME (Type or print) <i>Docia Ellen Crouse</i>			2a. DATE OF DEATH Month <i>May</i> Day <i>6</i> Year <i>1969</i>			2b. HOUR <i>1:08</i> M					
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>May 28, 1888</i>		6. AGE (In years lost birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford Co.</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Harford</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>RT 2 CASTLETON Rd.</i>	
14. FATHER'S NAME First <i>Wylfe</i> Middle <i>Candill</i> Last <i>Candill</i>			15. MOTHER'S MAIDEN NAME First <i>FRANCES</i> Middle <i>Crouse</i> Last <i>Crouse</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>			16b. SOCIAL SECURITY NO. <i>220-03-3057-A</i>			17. INFORMANT (Gou) <i>NO PHONE</i> T2.F.D.#2 <i>Address Room #31</i> <i>Mr. Melvin F. Crouse Darlington, Maryland 21034</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.U.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>> 1 year</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonitis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M.</i> <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-14</i> , 19 <i>69</i> , to <i>5-6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-6</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>			22c. DATE SIGNED <i>5/6/69</i>			22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>			22e. ADDRESS <i>Harford Co., Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>May 9, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>			23d. LOCATION (City or Town) (County) (State) <i>Bel Air, Harf. Co., Maryland 21014</i>		
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>			ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>			25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

09620

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06930

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06927

1. DECEASED-NAME (Type or Print)		First VERN	Middle ALLEN	Last DAVIS	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> May 22 1969		2b. HOUR 11:50 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8 Jan. 1931	6. AGE (In years in birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year May 22 1969	2d. HOUR 11:50 M
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Edgewood Arsenal		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Army Dispensary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier (Ret)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Lafayette de Grac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 40 Robinhood Road		14. FATHER'S NAME First Middle Last William S. Davis (D)		15. MOTHER'S MAIDEN NAME First Middle Last Helen M. Nixon (D)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) Korean		16b. SOCIAL SECURITY NO. 280-22-3793		17. INFORMANT ADDRESS Gisela F. Davis, Aberdeen, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 9239 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:50 5-22 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Explosion			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Office Building		21f. LOCATION Street or R.F.D. No. Edgewood Arsenal		City or Town Harford	
				State Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (Inspection <input checked="" type="checkbox"/> , (Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , (Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bel Air, Md.		22b. DATE SIGNED 5-22-69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 27 May 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Ft. Myer, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR DATE MAY 27 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

00030

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06931

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06928

1. DECEASED-NAME (Type or Print) HARRY GOUGH DAY			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month MAY Day 4 Year 1969			2b. HOUR 4:10 PM					
3. SEX MALE	4. RACE CAU	5. DATE OF BIRTH OCT 25, 1895	6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month MAY Day 4 Year 1969			2d. HOUR 4:10 PM		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD					
10. CITY OR TOWN OF DEATH BEL AIR			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1234 CONOWINGO Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAIL CARRIER			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1234 CONOWINGO Rd.		
14. FATHER'S NAME WILLIAM H DAY			15. MOTHER'S MAIDEN NAME ELIZA BANNISTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 220-44-3823		17. INFORMANT (B-38-4256) CLARA B. DAY ADDRESS WIFE - Same Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) OVER 6 YRS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Philip W. Heuman			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED MAY 4, 1969					
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 307 HICKORY AVE					
			ADDRESS (Street, city, town, or county) BEL AIR, Md								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Rock Spring Episcopal Ch. Cem.			23d. LOCATION (City or Town) (County) (State) Forest Hill Harford Co. Maryland 21050				
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

Harold G. Smith

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W. A. Smith

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FOR STATE
HEALTH DEPT.

06932

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06929

1. DECEASED-NAME (Type or Print) Leslie A. Dickey			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR May 14 1969 M		
3. SEX M	4. RACE W	5. DATE OF BIRTH 8/23/1889	6. AGE (in years lost birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month May 14 Day 14 Year 19 69 2d HOUR 4P M		
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Floor finisher		12b. KIND OF BUSINESS OR INDUSTRY Floor Finishing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Arthur James Dickey		First Middle Last		15. MOTHER'S MAIDEN NAME Hattie Bell Hayden		First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-22-6159		16c. INFORMANT Mrs. Anna M. Dickey		16d. ADDRESS 108 N. Lynbrook Road Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 890X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon Monoxid DUE TO, OR AS A CONSEQUENCE OF (c) Fire.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5-14 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Burned while polishing floor				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Bel Air, R.D. 3		City or Town Ha. Md. County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>								
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bel Air, Md.		22b. DATE SIGNED 5-14-69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/17/1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford, Md.		
24. FUNERAL DIRECTOR Charles E. Kurtz				ADDRESS Jarrettsville, Md. 21084		25a. REC'D BY REGISTRAR DATE MAY 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is
 necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
 the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
 Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05/27/59

Memorandum

J. Edgar Hoover

TO : DIRECTOR, FBI (100-361151)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

RE: [Illegible]
100-361151
100-100000

[Extremely faint and mostly illegible body text of the memorandum, appearing to be several paragraphs of typed text.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06930

1. DECEASED-NAME (Type or Print)		First John S.		Middle Ditch		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Mated <input checked="" type="checkbox"/> May 10 1969		2b. HOUR 11	
3. SEX M	4. RACE W	5. DATE OF BIRTH Dec. 18, 1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month May Day 10 Year 1969	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford				Md.	
10. CITY OR TOWN OF DEATH HAVERDE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEM.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CREDIT MANAGER		12b. KIND OF BUSINESS OR INDUSTRY AMEO. O'LG					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY HARFORD BELAIR		13c. CITY OR TOWN BELAIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8 BONNIE AVE.			
14. FATHER'S NAME First Purnell		Middle Ditch		Last MARY		15. MOTHER'S MAIDEN NAME First CLARK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-01-1793		17. INFORMANT Nicola Ditch		ADDRESS 8 BONNIE AVE. BELAIR, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Gerald C Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5-10-69			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) Bel Air, Md. 21014							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-14-69		23c. NAME OF CEMETERY OR CREMATORY ST John's		23d. LOCATION (City or Town) (County) (State) Ellicott City Harford MD					
24. FUNERAL DIRECTOR Higinbotham-Slack				ADDRESS Ellicott City, Md.				25a. REC'D BY REGISTRAR May 13 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

2520

06934

CERTIFICATE OF DEATH

06931

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Paul Sydney Draper			2a. DATE OF DEATH Month 5 Day 10 Year 69			2b. HOUR 9:15 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 9, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Harre-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK		12b. KIND OF BUSINESS OR INDUSTRY Civil Service			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 17 E. Courtland ST	
14. FATHER'S NAME First Frank Middle Rusey Last Draper			15. MOTHER'S MAIDEN NAME First Sidney Middle Davis Last Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-20-7458-A		17. INFORMANT (See No 5-6006) Mr. Frank S. Draper Address 1615 Harding Ave. Baltimore, Maryland 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Cardiac Decompensation 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-28 , 19 69 , to 5-10 , 19 69 , that (I) (we) last saw the deceased alive on 5-10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dante H. Monakik, M.D.				22c. DATE SIGNED 5-10-69		22d. PHYSICIAN'S NAME (Type) DANTE H. MONAKIK, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23e. REC'D BY REGISTRAR MAY 13 1969	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS West Broadway & Williams St. BEL AIR, Maryland 21014		25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last MAE A (Ann M) DUNN					2a. DATE OF DEATH Month Day Year May 2nd, 1969			2b. HOUR M 	
3. SEX Female		4. RACE White		5. DATE OF BIRTH January 1911		6. AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co. Md.			
10. CITY OR TOWN OF DEATH Belair		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Tudor Hall, Belair, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY 			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Tudor Hall, Belair		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Kathryn Butryn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 105-03-8343		17. INFORMANT Address Mrs. Dorothy E. Fox-Tudor Hall Belair					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 ASCVD (Arteriosclerotic Cardiovascular Disease) DUE TO, OR AS A CONSEQUENCE OF (b) + Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 69 , to 5/2 , 19 69 , that (I) (we) lost saw the deceased alive on 4/10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lewid Kahan				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/9/69			
22d. PHYSICIAN'S NAME (Type) Lewid Kahan M.D.				22e. ADDRESS Trimble & Edgewood Rds. Belair					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/5/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto.			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd.				25a. REC'D BY REGISTRAR DATE MAY 13 1969		25b. REGISTRAR'S SIGNATURE William Judge			

28930

• **PLATO**

0-7-8341-1983-7

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06936									
CERTIFICATE OF DEATH									
06933									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Rose Naomi Eads					Month Day Year May 28, 1969			10A. M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		September 2, 1888		80 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore, Md.		U.S.A.				Harford County, Md.		Homemaker	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Forest Hill		2243 Rock Spring Road		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Forest Hill				2243 Rock Spring Road	
14. FATHER'S NAME First Middle Last William George Cooper				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Ann Collison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Name) Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		217-01-3610		Rev. C. Carroll Eads 2243 Rock Spring Road Forest Hill, Maryland 21050		7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Typhemia due to Carcinoma of Colon</u> 153.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1960</u> , to <u>May 28, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Willard P. Hudson				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 28, 1969			
22d. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				22e. ADDRESS Forest Hill, Maryland 21050					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 31, 1969		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR Joseph William Foster				W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Miles Judge	

2000

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06937 CERTIFICATE OF DEATH 06934										
1. DECEASED-NAME (Type or print) First Middle Last Joseph Spencer Elliott					2a. DATE OF DEATH Month Day Year 5 22 69			2b. HOUR 9 ³⁰ A M		
3. SEX M		4. RACE W		5. DATE OF BIRTH Oct. 20, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.				
10. CITY OR TOWN OF DEATH HAYRE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WARE HOUSE MAN		12b. KIND OF BUSINESS OR INDUSTRY A.S.S.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY Harford		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 635 Linden Lane	
14. FATHER'S NAME First Middle Last Wm Elliott			15. MOTHER'S MAIDEN NAME First Middle Last Mary Cantler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 216-05-2407		17. INFORMANT Address GRACE D. ELLIOTT, HAYRE DE GRACE MD. 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4123 Sudden Cardiac Decompression DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bilateral Basilar Pneumonia										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 5-16, 1969, to 5-22 1969, that (I) (we) last saw the deceased alive on 5-22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dante U. Monakic MD					22c. DATE SIGNED 5/22/69		22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIC, M.D.			
22e. ADDRESS 211 N. Union Ave. Harford Co. Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MAY 25 1969		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAYRE DE GRACE HARFORD MD.				
24. FUNERAL DIRECTOR R. Madison Mitchell					25a. RECD BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

56235

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06938

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06935

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
Kenneth James Fender						MAY 31 1969			1:10 P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	4/26/1906	63 YRS.					MAY 31 1969			1:10 P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.		
N. C.		U.S.A.				Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bel Air			Conowingo Road			Farmer			Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Harford			Bel Air			Conowingo Road		
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost								
Thomas M. Fender			Sarah Jane Edwards								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			218-32-3124			James K. Fender			RD #1, Box 237 Pylesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARDIAC ASTHMA - HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL HOURS</u> <u>SEVERAL YEARS</u>									21132		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
PHILIP W. HELMAN			M.D.						MAY 31, 1969		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			307 HICKORY AVE BEL AIR, MD 21014		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/3/1969			Mt. Zion			Bel Air, Harford, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Charles E. Kurtz			Jarrettsville, Md.			DATE JUN 2 1969			V. Charles Judge		

00000

RECEIVED THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

Approved: _____
Special Agent

Date: 10/10/50

To: Mr. J. Edgar Hoover, Director, FBI

From: Mr. J. Edgar Hoover, Director, FBI

Subject: [Illegible]

Re: [Illegible]

Reference is made to [Illegible]

Very truly yours,
[Illegible]

Very truly yours,
[Illegible]

cc: [Illegible]

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1621

1

06939

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06936

1. DECEASED-NAME (Type or print) Joshua Eugene Fisher			2a. DATE OF DEATH Month 5 Day 16 Year 69			2b. HOUR M					
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 1-1-1905		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD CO Md.					
10. CITY OR TOWN OF DEATH BEL AIR			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Labor			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STATION SERVICES			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Harford		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 203 Archcrest		
14. FATHER'S NAME First Thomas Middle Fisher Last Mabel Copper			15. MOTHER'S MAIDEN NAME First Mabel Middle Copper Last Fisher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 213-14-3129			17. INFORMANT VELLA A Fisher			Address BEL AIR MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621 (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes mellitus, asthma, emphysema, chronic myocarditis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 5 Day 19 Year 69 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. FOREST HILL, MARYLAND City or Town 21050 County MD State MD					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1964 , to MAY 16, 1969 , that (I) (we) last saw the deceased alive on MAY 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Barthel			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED MAY 19 1969		
22d. PHYSICIAN'S NAME (Type) ROBERT BARTHEL M.D.			22e. ADDRESS FOREST HILL, MARYLAND 21050								
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-19			23b. DATE 5-19			23c. NAME OF CEMETERY OR CREMATORY Asbury Cem			23d. LOCATION (City or Town) (County) (State) BEL AIR MD MD		
24. FUNERAL DIRECTOR Fitts George			ADDRESS BEL AIR			25a. RECD BY REGISTRAR MAY 21 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

2323

1924

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2013

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413 Maryland State Department of Health
5-24-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06940

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06937

1. DECEASED-NAME (Type or Print) RUTH		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year May 29, 1969		2b. HOUR 3:20 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 3, 1914		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year May 29, 1969	
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford				Md.	
10. CITY OR TOWN OF DEATH Harve-de-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1406 Belcamp Road			
14. FATHER'S NAME John Johnson		First		Middle		Last		15. MOTHER'S MAIDEN NAME Mary Cimen		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-32-9946		17. INFORMANT C. Donald Foote, Bel Air, Maryland		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death during caudal anesthesia 1541 DUE TO, OR AS A CONSEQUENCE OF for surgery of rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Adenocarcinoma of rectum											
19a. DATE OF OPERATION Scheduled (5-29-69)		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Carcinoma of rectum		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5-29- 19 69 PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Therapeutic misadventure							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital		21f. LOCATION Street or R.F.D. No. City or Town County State Havre de Grace Harford Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 5/30/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Md.					
24. FUNERAL DIRECTOR Walter A. ...		ADDRESS ... Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR FILE
10-1-58

03800

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-1-58 BY 1043

0000

Handwritten signature

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-1-58 BY 1043

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06941

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06938

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR			
Isabelle Gertrude Friedell						MAY 26 1969				1:00 PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	11/24/1916	52 YRS.	MONTHS DAYS		HOURS MIN.		MAY 26 1969				8:30 PM	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				
Balto. Md.			U.S.		WIDOWED		DIVORCED		Harford Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Norrisville			Long Corner Road			Proof Reader-Waverly Press							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.			Harford		White Hall		YES NO		RD #2 Box 197 Long Corner Road				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.				
Thomas Friedell			Isabel Streckfus			no			238-20-7593				
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			20. AUTOPSY?				
Mrs. Charles A. Collier, sister,			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARBON MONOXIDE POISON 9520 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUICIDE DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			30 MIN			YES NO				
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED				
PRIMARY OR CONTRIBUTING CAUSE OF DEATH			HOUR A.M. P.M.			RAN CAR IN CLOSED GARAGE			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				
21f. LOCATION Street or R.F.D. No.			21g. LOCATION City or Town			21h. LOCATION County			21i. LOCATION State				
RD #2 Box 197, WHITE HALL, HARFORD, MD			HOME			RD #2 Box 197, WHITE HALL, HARFORD, MD			RD #2 Box 197, WHITE HALL, HARFORD, MD				
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			MAY 26, 1969				
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			301 HICKORY AVE.			BEL AIR, MD 21014				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			5/29/69			Holy Redeemer Cem.			Baltimore, Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Schimunek Funeral Home, Inc. 3331 Brehms Lane						MAY 28 1969			Charles Judge				

00041

FOR SIGN
EACH DAY

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TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06942

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06939

1. DECEASED-NAME (Type or print)		First JAMES	Middle WILLIAM	Last HAUENSTADT	2a. DATE OF DEATH Month 28 Day Year 69		2b. HOUR 5 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH Sept. 22, 1889		6. AGE (In years last birthday) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.			
10. CITY OR TOWN OF DEATH HARFORD DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Boiler Fireman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN PORT DEPOSIT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT #1 R.F.D.	
14. FATHER'S NAME First Middle Last JAMES WILLIAM HAUENSTADT		15. MOTHER'S MAIDEN NAME First Middle Last NANNIE BOWLES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 226-267955A		17. INFORMANT Mrs. Bessie Brown		Address Port Deposit, Md.			
18. CAUSE OF DEATH (Enter only one cause per line. (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute anterolateral myocardial infarction 5 days</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infarction - Cardiac Decompensation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u> ?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Atelectasis of right middle & lower lobes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 1969, to 5/28, 1969, that (I) (we) last saw the deceased alive on 5/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward C. Loo, M.D.		22c. DATE SIGNED 5/28/69		22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Harford de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-31-69		23c. NAME OF CEMETERY OR CREMATORY New Bridge Baptist Rising Sun		23d. LOCATION (City or Town) (County) (State) Cecil Md.			
24. FUNERAL DIRECTOR Lemon E. McMillen		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE William Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 11-1-68

06943		MIDDLE				LAST		2a. DATE OF DEATH				2b. HOUR	
1. DECEASED-NAME (Type or print)		First		Middle		Last		May 22 1969				11:00 AM	
GEORGE		EMIL		HECKNER, SR.									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS			
Male		White		Oct. 20, 1889		79 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		USA				Harford				Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		15 Mountain Road		Contractor		building							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Md.		Harford		Fallston				15 Mountain Road					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Frederick		--		Heckner				Elizabeth		-- Leurs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address							
no		218-14-8584		Mary Catherine Heckner, 15 Mountain Road		Fallston, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 year</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 year</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , to <u>May 5, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Charles Richardson Jr</u>		22c. DATE SIGNED May 22, 1969		22d. PHYSICIAN'S NAME (Type) Charles Richardson, Jr.		22e. ADDRESS Bel Air, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 26, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City or Town) (County) (State) Bradshaw Balto. Md.							
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE <u>Richardson Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06944

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film 412 5/9/69 kk

CERTIFICATE OF DEATH

06941

1. DECEASED-NAME (Type or print) William			First A.			Middle Hester			Last			2a. DATE OF DEATH 5 Month 1 Day 69 Year			2b. HOUR 0045a		
3. SEX Male			4. RACE Caucasion			5. DATE OF BIRTH 20 May 1920			6. AGE (In years last birthday) 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) North Carolina			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford						Md.		
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital			12a. USUAL OCCUPATION (Kind of work done during usual working life, even if retired.) Motel Manager			12b. KIND OF BUSINESS OR INDUSTRY Motel								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Tuckaway Motel, 744 Phila Rd					
14. FATHER'S NAME Wiley			First Hester			Middle Clara			Last Hilton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 1940-1968 244-12-7438			17. INFORMANT Helen J Hester, Tuckaway Motel, 744 Phila Rd.			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Samuel Andelman			DEGREE CPT MC			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED May 1, 1969								
22d. PHYSICIAN'S NAME (Type) Samuel Andelman, CPT, MC			22e. ADDRESS US Kirk Army Hospital, APG, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial			23b. DATE May 3, 1969			23c. NAME OF CEMETERY OR CREMATORY Roselawn Cemetery			23d. LOCATION (City or Town) (County) (State) Decatur, (Morgan Co.) Ala.								
24. FUNERAL DIRECTOR Tarring Funeral Home			ADDRESS Aberdeen, Md. 21001			25a. REC'D BY REGISTRAR MAY 5 1969			25b. REGISTRAR'S SIGNATURE [Signature]								

00044

STANDARD FORM NO. 64

UNITED STATES GOVERNMENT

A

1. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
2. Name of the person or organization making the report: *Mr. J. Edgar Hoover*
3. Title of the report: *Report on the activities of the American People's Party*
4. Date of the report: *January 1, 1960*

5. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
6. Name of the person or organization making the report: *Mr. J. Edgar Hoover*
7. Title of the report: *Report on the activities of the American People's Party*
8. Date of the report: *January 1, 1960*

9. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
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20. Date of the report: *January 1, 1960*

21. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
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23. Title of the report: *Report on the activities of the American People's Party*
24. Date of the report: *January 1, 1960*

25. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
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27. Title of the report: *Report on the activities of the American People's Party*
28. Date of the report: *January 1, 1960*

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30. Name of the person or organization making the report: *Mr. J. Edgar Hoover*
31. Title of the report: *Report on the activities of the American People's Party*
32. Date of the report: *January 1, 1960*

33. Name of the person or organization to whom the report is made: *Mr. J. Edgar Hoover*
34. Name of the person or organization making the report: *Mr. J. Edgar Hoover*
35. Title of the report: *Report on the activities of the American People's Party*
36. Date of the report: *January 1, 1960*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06945									
06942									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Della L. Hopkins					Month Day Year 5 - 19 - 1969			3A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
Female		White		11-12-1889		79 YRS.		MONTHS DAYS HOURS MIN 6 7 -	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		U.S.A.	
Harve de Grace, Md.		Harve de Grace, Md.		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Harford		Harve de Grace		YES		Rt. #2, Box 317	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last SUMMERFIELD RIGBY JONES		First Middle Last MARTHA JONES				214-18-7092		NOBLE H. HOPKINS, HARVE DE GRACE MD 021078	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A.S.C.U.D. DUE TO, OR AS A CONSEQUENCE OF (c)								2 YRS 10 YR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
Senility, Cerebral thrombosis									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1969, to May 18, 1969, that (I) (we) lost the deceased alive on May 18, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE John D. Yun		22c. DATE SIGNED 5/20/69		22d. PHYSICIAN'S NAME (Type) John D. Yun		22e. ADDRESS HARVE DE GRACE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		MAY 21, 1969		ROCK ROCK CEM.		HARFORD CO. MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE			
R. Madison Webb Harve de Grace, Md.		MAY 22 1969		Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 412 5-20-69 06946 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 06943											
1. DECEASED-NAME (Type or print) Albert						First M		Middle Ireland		Lost	
2a. DATE OF DEATH May						Month 7		Day 69		Year	
3. SEX Male		4. RACE Caucasion				5. DATE OF BIRTH 30 August 1962				6. AGE (In years lost birthday) 6 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH APG				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD 1 Box IX 372-A	
14. FATHER'S NAME Marcus				First M		Middle Ireland		15. MOTHER'S MAIDEN NAME Rosemarie Evelyn Courts		First Evelyn Middle Courts	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Marcus M. Ireland, RD 1 Aberdeen Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 0830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bizarre acute illness DUE TO, OR AS A CONSEQUENCE OF Histology revealed a rickettsial disease, most probably Rocky Mountain Spotted Fever. (c) disease, most probably Rocky Mountain Spotted Fever.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5 May , 19 69 , to 7 May , 19 69 , that (I) (we) last saw the deceased alive on 7 May 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard H. Heller						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 7 May 69			
22d. PHYSICIAN'S NAME (Type) Richard H. Heller, MD						22e. ADDRESS Kirk Army Hospital, Aber. Prov. Gd. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9 May 1969		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Aberdeen (Harford) Maryland	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001						ADDRESS		25a. REC'D BY REGISTRAR MAY 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
James Paul Kneucker						Month Day Year		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	Aug. 24, 1951	47 YRS.	MONTHS DAYS	HOURS MIN.	Month Day Year		M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Harford			Harford Memorial Hospital			Student			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md.			Cecil		Perryville	YES <input type="checkbox"/> NO <input type="checkbox"/>	Box 71A RD 1		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Andrew Kneucker			Mary Jo Evans						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			Unknown		Mary Jo Kneucker, Perryville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull									
819.9 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			5-16 69		Auto Accident				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		N.E. Rt. 40		Md Rt. 7		Aberdare		Harford	Md.
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Gerald C. Palmer			M.D.			5-17-69			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
Gerald C. Palmer, M.D.			Bel Air, Md.			21014			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/20/1969		West Nottingham Cemetery		Calona Cecil Md.			
24. FUNERAL DIRECTOR			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Lee A. Patterson & Son, Perryville, Md.			MAY 26 1969			Charles Judge			

52220

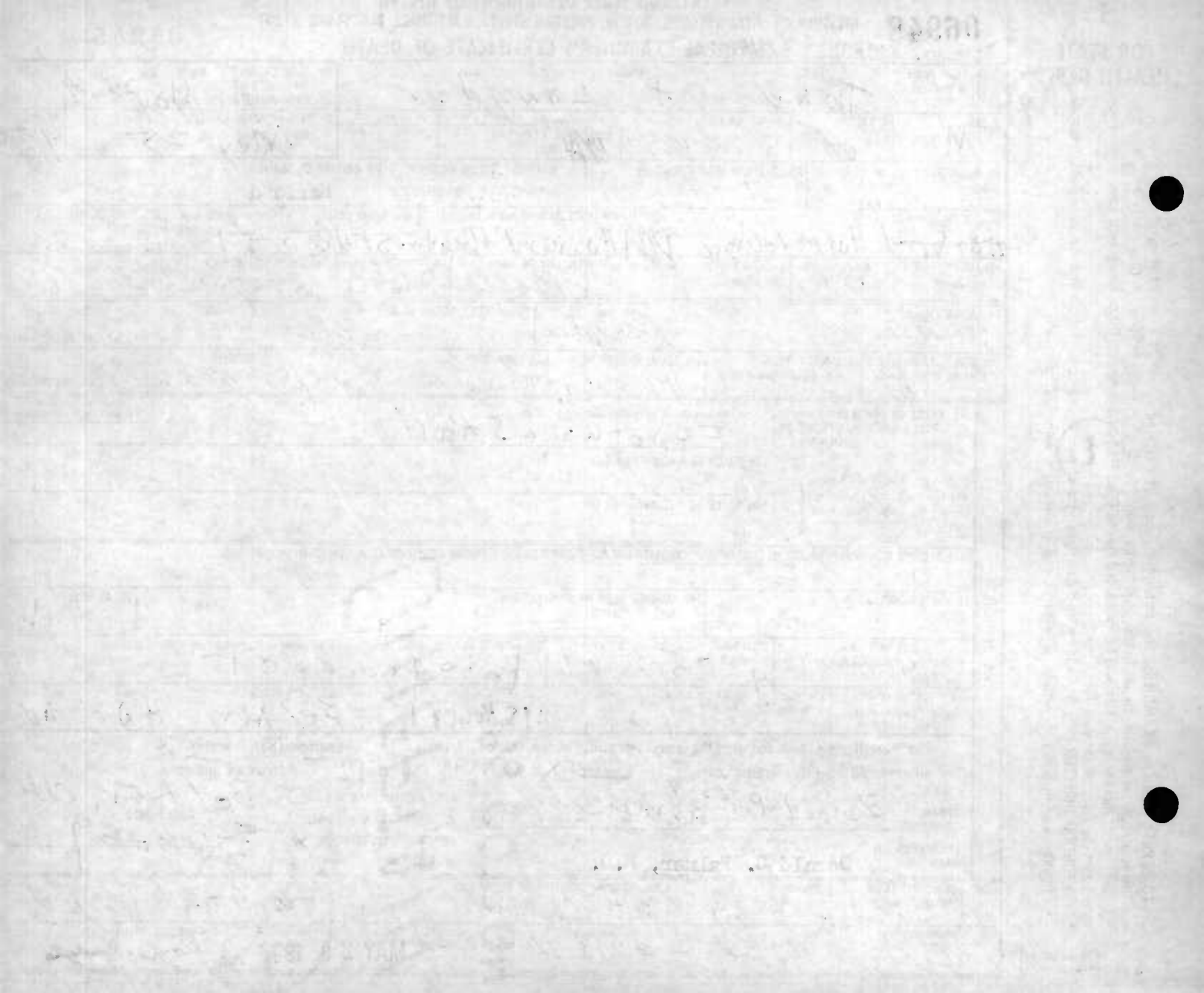
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>06948</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item #6, Film G413 6/</div> </div>										<div> <div>06945</div> </div>									
1. DECEASED-NAME (Type or Print) John H Langdon										2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> May 25 1969		2b. HOUR M							
3. SEX M		4. RACE W		5. DATE OF BIRTH 8-23-1893		6. AGE (In years last birthday) 76 1/2 YRS. <div> IF UNDER 1 YEAR MONTHS DAYS </div>		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD May 25 1969		2d. HOUR 4:30 M							
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford										
10. CITY OR TOWN OF DEATH Harford, Harford Co. Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pen. R.R.				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2907 Eastern Ave.									
14. FATHER'S NAME First Middle Last William Langdon					15. MOTHER'S MAIDEN NAME First Middle Last Ida Milka														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 717-07-6117		17. INFORMANT Mrs. Johanna Rudolph				ADDRESS 502 S. Ellwood Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 5-25-69 HOUR 4:30 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) US Route 1				21f. LOCATION Street or R.F.D. No. City or Town County State Belt Air Harford Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Gerald C. Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Belt Air, Md.				22b. DATE SIGNED 5-26-69											
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ADDRESS (Street, city, town, or county)																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 5-31-69		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel				23d. LOCATION (City or Town) (County) (State) Balto Md.									
24. FUNERAL DIRECTOR Thelma A. Hoffmann						ADDRESS 3218 Hudson				25a. REC'D BY REGISTRAR MAY 29 1969		25b. REGISTRAR'S SIGNATURE Charles J. ...							



06949

CERTIFICATE OF DEATH

06946

1. DECEASED-NAME (Type or print) NEONELA			First Middle Last			2a. DATE OF DEATH Month Day Year 5 22 69			2b. HOUR 2210 P		
3. SEX FEMALE			4. RACE CAU.			5. DATE OF BIRTH 23 JAN 16			6. AGE (In years last birthday) 53 YRS.		
7a. BIRTHPLACE (State or foreign country) ODessa, RUSSIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH ABERDEEN PROV. GR			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US AIR ARMY HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY N/A.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Aber. Prov.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME JUSTIN			First Middle Last			15. MOTHER'S MAIDEN NAME Feodora Savin			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4279 4279 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Electrical imbalance DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 22 May , 19 69 , that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural causes											
22b. SIGNATURE Jose Tomas Solano			22c. DATE SIGNED 22 May 69			22d. PHYSICIAN'S NAME (Type) Jose Tomas Solano			22e. ADDRESS K. H. H.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 26 May 1969			23c. NAME OF CEMETERY OR CREMATORY Post Cemetery			23d. LOCATION (City or Town) (County) (State) Aberdeen Proving Ground, Md.		
24. FUNERAL DIRECTOR Walter Wocacabin Sr.			Address Aberdeen, Md. 21001			25a. REC'D BY REGISTRAR MAY 27 1969			25b. REGISTRAR'S SIGNATURE William Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08000

CERTIFICATE OF DEATH

10-10-10

[Faint, illegible text and markings on a form, possibly a death certificate. The text is mirrored and difficult to decipher.]

[Faint, illegible text at the bottom of the page, possibly a signature or date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

2

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06950		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06947		
1. DECEASED-NAME (Type or print) <i>Dorothy L Lilley</i>						2a. DATE OF DEATH Month <i>5</i> Day <i>21</i> Year <i>69</i>		2b. HOUR M
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-3-1910</i>		6. AGE (In years lost birthday) <i>58</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Hartford</i>		
10. CITY OR TOWN OF DEATH <i>Hartford</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Hartford</i>		13c. CITY OR TOWN <i>Hartford</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>31 Locust St.</i>
14. FATHER'S NAME First <i>William</i> Middle <i>Stimax</i> Last <i>Owens</i>		15. MOTHER'S MAIDEN NAME First <i>Beulah</i> Middle <i>Owens</i> Last <i>Owens</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Arthur F. Lilley, Hartford, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF <i>Ventricular fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>A.S. Enticella</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S. Enticella</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>?</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>5-21, 1969</i> , to <i>5-21, 1969</i> , that (I) (we) last saw the deceased alive on <i>5-21, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Edward C. Loo</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>5/21/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, MD</i>		22e. ADDRESS <i>Hartford, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/25/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hartford, Md.</i>		
24. FUNERAL DIRECTOR <i>Wm. J. Patterson, Jr., Baltimore, Md.</i>		25a. REC'D BY REGISTRAR <i>MAV 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>				

06350

CERTIFICATE OF DEATH

WILLIAM HENRY HARRIS, 1811-1870, BORN IN NEW YORK, DIED IN NEW YORK

1870

WILLIAM HENRY HARRIS, 1811-1870, BORN IN NEW YORK, DIED IN NEW YORK

WILLIAM HENRY HARRIS, 1811-1870, BORN IN NEW YORK, DIED IN NEW YORK

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WILLIAM HENRY HARRIS, 1811-1870, BORN IN NEW YORK, DIED IN NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

403 X

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Julia Rebecca			MARTIN			May 17 1969			1:08 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		colored		3/26/1910		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
South Carolina		USA				HARFORD Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
AURE de Grace			HARFORD Mem. Hosp.			Maryland			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Cecil		Port Deposit		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT 1 - Box 210
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry			Simms			Ethel Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			Unknown		Henry S. Martin, Port Deposit, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 403 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Nephrosclerosis - Uremia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-17-1969</u> , to <u>5/17, 1969</u> , that (I) (we) last saw the deceased alive on <u>5-17-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Guenter D. Hirsch MD</u>						22c. DATE SIGNED <u>5/17/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Guenter D. Hirsch MD</u>						22e. ADDRESS <u>Aure de Grace, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/21/69		Cokesbury Baptist Com.		Port Deposit Cecil Md			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>W. L. Johnson Sr., Perryville, Md.</u>				MAY 26 1969		<u>Charles Judge</u>			

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06952

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06949

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 1 3 1969			2b. HOUR 9 pM		
JASPER			L. McCOY								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
Colored	Male	3-28-1969	YRS. 2			May 13 1969			9 pM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Mo.		
Libertown, Md.		U. S. A.				Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace			Harford Memorial Hospital			None			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Harford			Havre de Grace			700 Union Ave.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Jasper Edison McCoy			Patricia Stevenson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
(If yes give war or dates of service)			infant			Mrs. Jasper E. McCoy			700 S. Union Ave Havre de Grace, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SDII (Interstitial pneumonitis)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 484X									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward F. Wilson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED May 14, 1969			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 17, 1969		Berkeley Cemetery			Washington, Md			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Elmer E. Bullock			Havre de Grace, Md			JUN 2 1969			[Signature]		

86053

ATTEST EXHIBIT A CERTIFICATE OF DEATH

SECTION OF VITAL RECORDS, DIVISION OF HEALTH, BUREAU OF VITAL RECORDS

1911

STATE OF NEW YORK
COUNTY OF NEW YORK

Name of Deceased		Date of Death	
John Doe		Jan 1, 1911	
Age		Sex	
35		Male	
Married		Cause of Death	
Yes		Heart Disease	
Occupation		Place of Death	
Teacher		Home	
Signature of Physician		Signature of Registrar	
J. Smith		A. Jones	
Date of Signature		Date of Signature	
Jan 1, 1911		Jan 1, 1911	

FOR STATE
HEALTH DEPT

06951

Item# 6 Film 113 6/2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR					
COLUMBUS		JACK		MC		CRAW								19		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
Male		White		10-4-27		42 YRS		MONTHS		DAYS		May		21		1969		8:00 P.M.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. COUNTY OF DEATH									
N. Carolina		U.S.A.										HARFORD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY															
Harford		Pennington's Funeral Home		Carpenter		Constructor															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER													
Md.		Harford		Havre de Grace		YES NO		R.F.D. #1													
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last							
J.C. McCraw								?													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT																	
W.U.		Unk.		Mary McCraw		566 Adams St. Harford Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		Multiple severe injuries																			
805.9																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO													
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year ? ? ? A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		Hit by train															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		R.R. tracks Penn. R.R. tracks (rural) Havre de Grace Harford Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																					
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																					
ACTUAL SIGNATURE		Charles S. Springate, M.D.		22b. DATE SIGNED		May 22, 1969															
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)															
		5/26/69		Angel Hill		Harford Md															
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Harford Md		MAY 27 1969		Charles Judge																	

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UNITED STATES DEPARTMENT OF AGRICULTURE

FOR THE
NATIONAL BUREAU

UNITED STATES

UNITED STATES

UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL BUREAU OF ECONOMIC RESEARCH
WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL BUREAU OF ECONOMIC RESEARCH
WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL BUREAU OF ECONOMIC RESEARCH
WASHINGTON, D. C.

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WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL BUREAU OF ECONOMIC RESEARCH
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06953 CERTIFICATE OF DEATH 06950											
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Ruth Ann McGrail						Month	Day	Year	12-15		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
female		white		11-15-94		74		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Balt. Co.		USA				Harford Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace			Citizens Nursing Home			Taxi Driver		auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Harford		Edgewood		YES		2114 Nuttal Avenue		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
John			--	Storey		Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			219-16-9031			Ellen Burbar, 2016 Armstrong St.,			Edgewood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Carcinoma of lungs										4 months	
1621 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) --											
DUE TO, OR AS A CONSEQUENCE OF											
(c) --											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Fracture of right hip (2) A.S.C.U.D. + (3) Senility											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION					
						Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/1, 1969, to 5/23, 1969, that (I) (we) last saw the deceased alive on 5/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
Edward C. Hoo, M.D.			5/23/69			Edgewood, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 27, 1969		Baltimore National Cemetery			Baltimore Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas & Son, Abingdon, Md.						DATE MAY 26 1969		Charles Judge			

46230

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 96952

12916 9 5 2

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05952

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06956

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06953

1. DECEASED-NAME (Type or Print)			First BOBBY			Middle JOE			Last MULLINS			2a. DATE KNOWN OF DEATH MAY 25 1969			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 1, 1946		6. AGE (In years last birthday) 23 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MAY 25 1969			2d. HOUR 5:35 PM				
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Harford Md.							
10. CITY OR TOWN OF DEATH Forest Hill (Rural)				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Deer Creek Church Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Manager				12b. KIND OF BUSINESS OR INDUSTRY Automobile							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford				13c. CITY OR TOWN Fallston				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME Orpha Snowden Mullins						15. MOTHER'S MAIDEN NAME Nora Mapp Stidom													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-44-2446				17. INFORMANT Orpha S. Mullins, Bynum Rd., 8888888 Md.						ADDRESS Forest Hill					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Drowning 9109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 5:35 AM May 25 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowned in farm pond											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm Pond-Deer Creek Ch. Rd. Rural				21f. LOCATION Street or R.F.D. No. Forest Hill				City or Town Harford				State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (inspection <input checked="" type="checkbox"/> , (inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , (Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Gerald C. Palmer						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 5-26-69							
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
						ADDRESS (Street, city, town, or county) Bel Air, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 29 May 1969				23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co. Md.							
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Md. 21001						25a. REC'D BY REGISTRAR JUN 2 1969						25b. REGISTRAR'S SIGNATURE Charles Judge							

25826

12

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1960

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
BERTHA			C. MURRAY			Month Day Year MAY 12 1969			1 ¹⁰ P. M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
FEMALE		Colored		July 27, 1891		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U.S.				HARFORD		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
HARFORD			HARFORD Memorial Hosp.			Domestic			Private Family
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md			HARFORD		BELAIR		YES		RD 1 Box 394
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
AL PARSON			ANNA SNOWDEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address	
no			216-12-61234		Mr. Earl G. Murray, Bel Air, Md.			RD #1 Box 394	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 174X Scirrhous C.A.L. breast c									3 yrs.
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) local recurrence and wide spread metastases									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to MAY 12 1969, that (I) (we) last saw the deceased alive on MAY 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
W H SADOWSKY									5/12/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
W H SADOWSKY					504 LEWIS ST. Harford, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-16-69		Clark's Chapel Cemetery		Bel Air, Harford, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Charles J. Sullcock, Harford, Md.					MAY 20 1969		Charles Judge		

REPORT OF DEATH

NAME OF DECEASED: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Name of physician: [illegible]
6. Name of funeral home: [illegible]
7. Name of next of kin: [illegible]
8. Signature of declarant: [illegible]
9. Date of report: [illegible]
10. Name of reporter: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR 151-4
45M - 1-69

06958										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH										06955																			
1. DECEASED NAME (Type or print) <i>Helen Elizabeth OGIER</i>					2a. DATE OF DEATH <i>5</i> Month <i>13</i> Day <i>69</i> Year					2b. HOUR <i>442</i> M																			
3. SEX <i>♀ (FEMALE)</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH <i>10/26/04</i>			6. AGE (In years last birthday) <i>64</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Hartford</i> Md.														
10. CITY OR TOWN OF DEATH <i>Haure de Grace</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Mem. Hosp.</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>					13b. COUNTY <i>Hartford</i>					13c. CITY OR TOWN <i>Joppa</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <i>1923 Old Joppa Rd.</i>									
14. FATHER'S NAME First <i>John</i> Middle <i>W.</i> Last <i>Treder</i>					15. MOTHER'S MAIDEN NAME First <i>Lora</i> Middle <i>Walper</i> Last <i>Walper</i>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. <i>212-05-5969</i>					17. INFORMANT <i>Lohn L. Ogier</i> Address <i>1924 Old Joppa Road Joppa, Md</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal shutdown</i> <i>5602</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Shock</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Peritonitis of sigmoid nodules</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>14 hours</i> <i>18 hours</i> <i>4-5 days</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congenital colon malformation</i>																													
19a. DATE OF OPERATION <i>9/12/69</i>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Voluntarily & peritonitis</i>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/8</i> , 19 <i>69</i> , to <i>5/13/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/13/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Aw Grigoleit</i>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>5/13/69</i>														
22d. PHYSICIAN'S NAME (Type) <i>A.W. GRIGOLEIT</i>										22e. ADDRESS <i>Haure de Grace, Md</i>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE <i>5-16-1969</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>					23d. LOCATION (City or Town) (County) (State) <i>Fullerton Baltimore Md</i>														
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i>										ADDRESS <i>7401 Belair Road 21236</i>					25a. REC'D BY REGISTRAR <i>DATE 1 5 1969</i>					25b. REGISTRAR'S SIGNATURE <i>William J. J...</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06959		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		06956	
Item 5 Film 413 6/4/69 kk		CERTIFICATE OF DEATH			
1. DECEASED NAME (Type or print) First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
MALCA ROTTENBERG		MAY 24 1969		6 40 AM	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		3/16/1897	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (In years last birthday)	
Poland		U.S.A.		72 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired.)	
Havre de Grace		Hartford Mem. Hosp		HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institutions. Residence before admission) STATE		13b. COUNTY		13c. STREET AND NUMBER	
Md		Hartford		607 Giles St.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
LAIS HERMAN		RACHEL ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		No		EDWARD J. ROTTENBERG-607 GILES ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124		Ventricular fibrillation		Sudden	
DUE TO, OR AS A CONSEQUENCE OF		(b) Arteriosclerotic Cardio-vascular Disease		2-3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 1969, to 5/24, 1969, that (I) (we) last saw the deceased alive on 5/24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED			
Edward C. Loo, M.D.		5/24/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Edward C. Loo, M.D.		Havre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/25/1969		HEBREW BROTHERHOOD BARRACADE MD.	
24. FUNERAL DIRECTOR		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sol Leiman		MAY 27 1969		William Judge	

CERTIFICATE OF DEATH

I hereby certify that on the 14th day of March 1914
 at the residence of the deceased, in the City of New York
 the following named person died:
 Name of deceased: *John J. [illegible]*
 Age: *60*
 Sex: *Male*
 Cause of death: *Heart disease*
 Signature of physician: *[illegible]*
 Signature of registrar: *[illegible]*
 Date: *March 14, 1914*

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06960

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06957

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
ROWLAND			GEORGE			SCHUMAN			May 22, 1969 1:00 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	May 17, 1945	24 YRS.	MONTHS	DAYS	HOURS	MIN.	May 22 1969			1:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			Md.
Md.		USA		WIDOWED		DIVORCED		Harford			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Edgewood			--			Foreman			chemical plt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Harford			Edgewood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
Rowland P.			Schuman			Peggy			1514 Emmorton Road, Edgewood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			215-42-8318			Nealie M. Schuman, 1514 Emmorton Road			Edgewood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 9239 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:50 P.M. 5:22 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Explosion					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Office Bldg.			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
					Edgewood Arsenal,					Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			3-1 A.S., md.		
EXAMINER'S NAME (Type)			Gerald C. Palmer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			May 22, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County) (State)	
Burial			May 24, 1969		Cokesbury Memorial Cemetery			Abingdon		Harford Md.	
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Howard K. McComas & Son, Abingdon, Md.									25b. REGISTRAR'S SIGNATURE		
						DATE MAY 26 1969			<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
06961									
06958									
1. DECEASED-NAME (Type or print) <i>PEARL</i> First <i>MARGARET</i> Middle <i>SHAFFER</i> Last			2a. DATE OF DEATH Month <i>MAY</i> Day <i>31</i> Year <i>1969</i>			2b. HOUR <i>8:15 A</i> M			
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JUNE 9 1895</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.			
10. CITY OR TOWN OF DEATH <i>HAURE DE GRACE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>STORE KEEPER HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>HAURE DE GRACE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>991 Chesapeake Drive</i>	
14. FATHER'S NAME <i>GEORGE</i> First <i>WOODLING</i> Middle <i>C LARA</i> Last			15. MOTHER'S MAIDEN NAME <i>RATHFEM</i> First <i>C LARA</i> Middle <i>RATHFEM</i> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>189-07-8687</i>		17. INFORMANT <i>Charles E. Shafer</i>		Address <i>Conowingo Md. 205</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Uremia</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Uterus</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <i>generalized Carcinomatosis</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>									
<i>1 yr.</i>									
<i>1 months</i>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>May 31</i> , 19 <i>69</i> , to <i>May 31</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>May 31</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Edward J. Simon</i>		22c. DATE SIGNED <i>5/31/69</i>		22d. PHYSICIAN'S NAME (Type) <i>EDWARD J. SIMON</i>					
22e. ADDRESS <i>HAURE DE GRACE, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>JUNE 2, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BELAIR MEMORIAL GARDENS</i>		23d. LOCATION (City or Town) (County) (State) <i>BELAIR HARFORD MD.</i>			
24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>		ADDRESS <i>HAURE DE GRACE MD.</i>		25a. REC'D BY REGISTRAR <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

06962										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06959																			
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR																			
Carroll Hamilton Smith										May 21, 1969										3 ⁴ M																			
3. SEX Male					4. RACE White					5. DATE OF BIRTH December 2, 1914					6. AGE (In years last birthday) 54 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Md					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. COUNTY OF DEATH Hartford Co., Md.																								
10. CITY OR TOWN OF DEATH Havre de Grace					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Mem Hosp.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dispatcher					12b. KIND OF BUSINESS OR INDUSTRY Quarry																								
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE Md					13b. COUNTY Baltimore Co.					13c. CITY OR TOWN Balto.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 2911 Emerald Ave.																			
14. FATHER'S NAME First Middle Last John Hamilton Smith					15. MOTHER'S MAIDEN NAME First Middle Last Gretta LEE Harkins					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO										16b. SOCIAL SECURITY NO. 216-30-1251					17. INFORMANT (Daughter) Mrs. Elaine S. Morgan Address 19422 McLaren Lane Huntington Beach California 92646														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4002 Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF Malignant Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? (c) ? PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bleeding peptic ulcer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from May 17, 1969, to May 21, 1969, that (I) (we) last saw the deceased alive on May 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Edward C. Loo, M.D.										22c. DATE SIGNED 5/21/69																			
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.										22e. ADDRESS Havre de Grace, Md.										22f. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE May 23, 1969										23c. NAME OF CEMETERY OR CREMATORY DEER CREEK MEm. Ch. Cem.										23d. LOCATION (City or Town) (County) (State) Forest Hill, Harford Co. Maryland 21050									
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014										25a. REC'D BY REGISTRAR MAY 22 1969										25b. REGISTRAR'S SIGNATURE																			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06963

06960

1. DECEASED NAME (Type or print) Stephen -- Staniec			2a. DATE OF DEATH Month May Day 78 Year 69			2b. HOUR 0630am	
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 25 December 1920		6. AGE (In years last birthday) 48 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? United States		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH APG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Army		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Alex -- Staniec		15. MOTHER'S MAIDEN NAME First Middle Last Victoria -- Siskoria		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) Oct 1960 to Oct 1966			
16a. SOCIAL SECURITY NO. 215-38-9466		17. INFORMANT Address Dolly Staniec 611 Longbar Harve Rd Abington					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma Expected Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11 April , 19 69 , to 8 May , 19 69 , that (I) (we) last saw the deceased alive on 8 May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carlos M. Del Valle				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 8 May 69	
22d. PHYSICIAN'S NAME (Type) CARLOS M. DELVALLE, CPT, MC				22e. ADDRESS US Kirk Army Hospital, AFG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 12, 1969		23c. NAME OF CEMETERY OR CREMATORY APG Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen Proving Ground Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son				25a. REC'D BY REGISTRAR DATE MAY 12 1969		25b. REGISTRAR'S SIGNATURE William Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Journal 18

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Journal of Management Education 33(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH						06961					
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Laura		Taylor						Month 5 Day 11 Year 69		1:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		August 25, 1877		91 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Va.		USA				Hartford Co.				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Havre de Grace		Hartford Memorial		Housewife		Homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		Hartford		Street				RD 1 Box 233			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Enoch		Hart						Jenny			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT (See 452-5922)		Address					
No		220-50-3560JL		Mr. Vaughn T. Taylor		RFD #1, Box # 233 Street, Maryland 21154					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Extensive Bilateral Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Septicemia											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Cardiac Decompensation sec to Arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 5-10, 1969, to 5-11, 1969, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Dante H. Monakic, M.D.		5/11/69		DANTE H. MONAKIC, M.D.		211 N. Union Ave. Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		May 14, 1969		Bel Air Memorial Gardens		Bel Air, Hartford Co., Maryland		21014			
24. FUNERAL DIRECTOR		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Joseph William Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		MAY 13 1969		Charles Judge					

00220

RECEIVED 10-20-1960

10-20-1960

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "10-20-1960" are visible.]

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 FILMG 112 5/20/69K MARYLAND STATE DEPARTMENT OF HEALTH													
06965 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
06962													
1. DECEASED-NAME (Type or Print) First Middle Last ROBERT E. VAN SYCKEL						2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <input type="checkbox"/> Unknown 19			2b. HOUR M				
3. SEX M		4. RACE W		5. DATE OF BIRTH 14 Dec. 1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year May 10 1969		2d. HOUR 57 P M	
7a. BIRTHPLACE (State or foreign country) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dorchester Memorial Hospital				12a. MECHANICAL ENGINEER (Killed during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rte 3			
14. FATHER'S NAME First Middle Last Unknown						15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO. WW-1		17. INFORMANT ADDRESS Earnest Bannister, Conowingo, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5-11-69 Bel Air, Md.					
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 13 May 69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematorium				23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)			
24. FUNERAL DIRECTOR <u>Walter Macomber Jr.</u>				Tarring Home Aberdeen, Md. 21001				25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>			

08863

VARICELLA

May 10 1917

History of Present Illness

On May 10, 1917, the patient was first noticed to have a fever and a rash on the face and neck.

Examination of throat

201/1/17
201/1/17

201/1/17

201/1/17

201/1/17

06966

CERTIFICATE OF DEATH

06963

1. DECEASED-NAME (Type or print) First Middle Last LAURA CORNELIA VAILLUX			2a. DATE OF DEATH Month Day Year May 18 1969			2b. HOUR 10:40 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH FEB. 22, 1895		6. AGE (In years last birthday) 74 YRS.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH HAVER LE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FILE CLERK		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Cecil		13c. CITY OR TOWN PORT DEPOSIT		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last John Methu			15. MOTHER'S MAIDEN NAME First Middle Last MASSIE LEAH MCGINNIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 578-05-1030		17. INFORMANT Address MRS GRACE BARROW, PORT DEPOSIT, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8-2-1968 , to 5-17-69 , that (I) (we) last saw the deceased alive on 5-16-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Neil R Taylor Jr MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) Neil R Taylor Jr MD				22e. ADDRESS Rising Sun, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/21/1969		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) Bladensburg, P.G. Md. D.C.		
24. FUNERAL DIRECTOR Ralph M. Reed				ADDRESS RISING SUN, MD.		25a. REC'D BY REGISTRAR DATE MAY 20 1969		
				25b. REGISTRAR'S SIGNATURE Charles J. Jones				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 5 M
45M

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) ALLAN BROOKER WALTERS		2a. DATE OF DEATH Month May Day 6 Year 69		2b. HOUR 2:00 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH Sept. 25-1889		6. AGE (In years last birthday) 79 YRS.
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAURE de GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY HARFORD	13c. CITY OR TOWN HAURE de GRACE	13d. STREET AND NUMBER 725 D Washington
14. FATHER'S NAME Albert Lewis		15. MOTHER'S MAIDEN NAME WALTERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 918-037444		
17. INFORMANT Stephen N. Adams		17a. ADDRESS 725 D Washington St Harford Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ant myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ASHO (b) ASA D DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic CA 70 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 25 years 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) card above				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 4-11 , 19 69 , to 5-6 , 19 69 , that (I) (we) last saw the deceased alive on 5-6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Mahman M		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) M. W. ISHAK, MD
22e. ADDRESS 504 Lewis Street Home Dept. 701		22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/9/69		23c. NAME OF CEMETERY OR CREMATORY Angel Hill
23d. LOCATION (City or Town) (County) (State) Harford Md		23e. REC'D BY REGISTRAR 12 1969		
24. FUNERAL DIRECTOR Frederick J. M. Howard		25b. REGISTRAR'S SIGNATURE William J. Judge		

72820

06968

CERTIFICATE OF DEATH

06965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle C. Last Watson		4. DATE OF DEATH Month May Day 9 Year 1969	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1871
9. AGE (In years lost birthday) yrs. 97		10. IF UNDER 1 Year Months 9 Days 12 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) York Co., Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wilkerson		14. MOTHER'S MAIDEN NAME Lucy Orman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-8668	
17. INFORMANT Raymond Watson		Address Whiteford, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 4122 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C V Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 9 1969 to May 9 1969 that (I) (we) last saw the deceased alive on May 9 1969 , and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE John A. Hunt		22b. DATE SIGNED May 10, 1969	
22c. PHYSICIAN'S NAME (Type) Dr. J. A. Hunt		22d. ADDRESS Delta, Pennsylvania	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 12, 1969	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR DATE MAY 14 1969	
ADDRESS Delta, Pa.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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06969

CERTIFICATE OF DEATH

06966

1. DECEASED-NAME (Type or print) HATTIE PEARSON WEBSTER			2a. DATE OF DEATH Month May Day 8 Year 1969			2b. HOUR 8:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 1, 1880		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 308 Plumtree Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 308 Plumtree Road							
14. FATHER'S NAME First Thomas Middle Jefferson Last Pearson			15. MOTHER'S MAIDEN NAME First Ellen Middle -- Last Beason				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (na, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 248-10-7881		17. INFORMANT Address Bel Air, Md. Miss Frances Beckelheimer, 308 Plumtree Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO. RESP. FAILURE 4409 DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED ARTERIOSCLEROSIS + SENILITY DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED. 6 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from OCT , 19 62 , to 8 MAY , 19 69 , that (I) (we) last saw the deceased alive on MAY , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H.P. Sidwell M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 9, 1969	
22d. PHYSICIAN'S NAME (Type) Harvey P. Sidwell, M.D.				22e. ADDRESS 401 Franklin St., Bel Air, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 11, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Emmorton Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR DATE MAY 12 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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08889

OFFICE OF DEPT.

08889

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ADVANCED ARTIFICIALS + SECURITY
INTD
08889

W. J. [Signature]
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div> <div>06970</div> <div>Item 6 Film 113 6/4/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>06967</div> </div>											
1. DECEASED-NAME (Type or print) Marian						First		Middle		Last	
3. SEX Female						4. RACE Caucasian		5. DATE OF BIRTH 11 Dec 1919		2a. DATE OF DEATH Month May Day 27 Year 69	
7a. BIRTHPLACE (State or foreign country) North Carolina						7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2b. HOUR 1214p M	
10. CITY OR TOWN OF DEATH Aberdeen PG, Md.						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE South Carolina						13b. COUNTY Richland		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Bruton Benjamin Finklea						First		Middle		Last	
15. MOTHER'S MAIDEN NAME Kitty Munn						First		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No						16b. SOCIAL SECURITY NO. 250-16-3740		17. INFORMANT Wilbur C. Wiggins, 2224 Cermak Dr. Columbia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aplastic Anemia DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 Hours 5 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 26 May , 19 69 , to 27 May , 19 69 , that (I) (we) last saw the deceased alive on 27 May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Carlos M. Delvalle								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 28 May 69	
22d. PHYSICIAN'S NAME (Type) Carlos M. Delvalle								22e. ADDRESS US Kirk Army Hospital, APG, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE 5/30/69		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City or Town) (County) (State) Florence South Carolina			
24. FUNERAL DIRECTOR Wilbur Macomber Sr.				ADDRESS Tarboro - Florence				25a. REC'D BY REGISTRAR DUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06971

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06968

1. DECEASED-NAME (Type or Print)		First WILLIAM	Middle REESE	Last WILLIAMS	2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 1969 May 8		2b. HOUR 8:50 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 5, 1908		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 1969 May 8
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant (Self-emp)		12b. KIND OF BUSINESS OR INDUSTRY Gen. Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME William Reese Williams (D)		15. MOTHER'S MAIDEN NAME Alice Kearney (D)		13e. STREET AND NUMBER Route #2, Box 320			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 216-03-0410		17. INFORMANT Hazel R. Williams, Aberdeen, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: (Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>)							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 May 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11 May, 1969		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen (Harford) Maryland	
24. FUNERAL DIRECTOR Walter Wocowich Jr.		Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR MAY 12 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

5523

1459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

06972		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06969	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) <i>Ella Elizabeth Wright</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>27</i> Year <i>69</i>			2b. HOUR <i>7:30</i> PM	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>November 29, 1900</i>		6. AGE (In years last birthday) <i>68</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.	
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>Schroder</i> Last <i>Schroder</i>		15. MOTHER'S MAIDEN NAME First <i>Caroline</i> Middle <i>Schaumbel</i> Last <i>Hell</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-07-8323-B</i>		17. INFORMANT Address <i>Mrs. Howard Oliver Sr, Aberdeen, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Respiratory Failure</i> <i>1459</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Metastatic Spread of Ca.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Of Mouth & Throat</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5-26, 1969</i> , to <i>5-27, 1969</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dante N. Monakic, MD.</i>				DEGREE <i>MD.</i>		22c. DATE SIGNED <i>5/27/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>DANTE N. MONAKIC, MD.</i>				22e. ADDRESS <i>211 N. Union Ave. Harre de Gr. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>29 May 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spesutia Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Perryman, (Harford Co) Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>				25a. RECEIVED BY REGISTRAR DATE <i>JUN 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

4379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 443 (4)
30M REV. 1/68

06973

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08469
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Marie First A. Middle Ziesel Last			2a. DATE OF DEATH Month 3 Day 69 Year 1969		2b. HOUR 4:30 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Sept 12 1880		6. AGE (In years lost birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Germany	7b. CITIZEN OF WHAT COUNTRY? US	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford County Md.		
10. CITY OR TOWN OF DEATH Aberdeen, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Kingsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Hillside Rd.	
14. FATHER'S NAME Frank First Kael Middle Last	15. MOTHER'S MAIDEN NAME Unknown First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. ? none		17. INFORMANT Theodore Boehmer Kingsville Md Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4379 (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (H) (this hospital) attended the deceased from 21 April, 1969 , to 31 May, 1969 , that (H) (we) last saw the deceased alive on 31 May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ch. Middle Cptmc DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 31 May 69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE May 31 1969		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
24. FUNERAL DIRECTOR Bruce Winslow		ADDRESS Benson Md		23d. LOCATION (City or Town) (County) (State) Bolton Md	
25a. RECEIVED REGISTRAR JUN 10 1969				25b. REGISTRAR'S SIGNATURE Charles Judge	

20288

MADE IN U.S.A.

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MADE IN U.S.A.